Statement of
Mary Ann Kehoe

Mr. Chairman and members of the Committee, I am Mary Ann Kehoe, Executive Director of Good Shepherd Services, Ltd., Seymour WI. Good Shepard is a not-for-profit facility that has 92 nursing care beds and also provides a range of community-based services, including case management, hospice care, and home-delivered meals.

I am here today as a member of the American Association of Homes and Services for the Aging (AAHSA). The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit written testimony to the United States Senate Special Committee on Aging. We consider the issue of staffing in long term care facilities, and its impact on quality of care to residents, to be one of critical importance.

AAHSA is a national nonprofit organization representing almost 6,000 not-for-profit providers of health care, housing, long-term care, and community services to almost 1,000,000 individuals daily. Approximately seventy-five percent of AAHSA members are affiliated with religious organizations, while the remaining are sponsored by private foundations, fraternal organizations, government agencies, and community groups. Our members include not only nursing facilities, but also independent senior housing, continuing care retirement communities, and providers of home health care, adult day care, respite care, meals on wheels, and other services. With strong community involvement and long-standing community ties, AAHSA and its members have long been committed to providing quality care to the people we serve and to meeting the needs of these individuals in a manner that enhances their sense of self-worth and dignity, and that allows them to function at their highest levels of independence. Although AAHSA's membership spans the continuum of long term care, the majority of our members continue to provide nursing facility (NF) and skilled nursing facility (SNF) care, either alone or in combination with other services.

Quality of Care in Nursing Facilities

The nursing home quality reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid. One of the most significant transformations resulting from the passage of OBRA '87 was the shift in focus of regulatory oversight from facilities' capacity to provide care, "paper compliance" with requirements, to one on resident outcomes, that is, the actual care provided.

Several of the nursing home quality reform provisions have facilitated this change in approach and have worked to improve the quality of care and assure better resident outcomes.

1. Standardized Resident Assessment (RAI/MDS)

Central to the OBRA '87 change from process to outcomes is the mandate that every facility conduct, "initially and periodically, a comprehensive, accurate, standardized,

reproducible assessment of each resident's functional capacity." These assessments are to be interdisciplinary in nature, to be conducted at least annually, reviewed quarterly, and revised in the event of a significant change in status. The resident assessment instrument and minimum data set (RAI/MDS) developed under the auspices of the Health Care Financing Administration

(HCFA) as a result of OBRA '87 has been successfully implemented on a national basis.

As a refinement to the process, the federal government has now developed a national system for computerization and transmission of the RAI/MDS data from each resident to a national database. Effective June 22, 1998, all participating facilities are required to electronically transmit MDS data. The data goes first to the states, and then to HCFA for inclusion in the national database. Theoretically, this will permit the government to compile individual resident profiles, to link individual assessments longitudinally, and to monitor outcomes for both improvement and decline. Over time, the MDS data can also be used to develop performance standard norms. The ability to track individual and collective resident outcomes on a longitudinal basis will allow targeting of oversight resources on facilities providing less than optimal care. The RAI system with its "feedback loop" to providers, can also serve as one piece of an effective internal quality assurance program.

Implementation and computerization of the RAI/MDS must be considered a major step forward in assuring accurate and individualized assessment and care planning for all nursing facility residents. However, the current process is not yet perfect, with some MDS items requiring further refinement. In practice, despite a voluminous instruction manual, there are problems with inter-rater reliability and/or variability in how individual facilities interpret the MDS questions. HCFA has always characterized the RAI/MDS as evolutionary in nature and has continued to work toward the accomplishment of these and other refinements.

2. Highest Practicable Physical, Mental, and Psychosocial Well-being

OBRA '87 also placed nursing facilities in the unique position of the being the only health care provider to be mandated to guarantee specific resident or patient outcomes. Under requirements for both Resident Assessment (CFR 483.20) and Quality of Care (CFR 483.25), nursing facilities must "provide and assure that each resident receives the necessary care and services to attain and maintain [his/her] highest practicable physical, mental, and psychosocial well-being." The interpretive guidelines for these requirements (State Operations Manual Transmittals #10,) state that "Facilities must ensure that each resident obtains optimal improvement or does not deteriorate [within the limits of the resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process]."

This language not only assures that resident outcomes will be stressed as a measure of quality of care, but also places a clear responsibility on nursing facilities not just to maintain the status quo, but to act aggressively to improve the resident's health status.

The focus on outcomes contained in the OBRA '87 nursing facility reform provisions has proved consistent with the increased emphasis on outcomes as a quality measure across provider types and health care settings. In this rising environment of managed care, the general trend for insurers and payers to want to know what they are getting for their dollars is one that has actually been written into statute for nursing facilities in the OBRA mandate for attainment of highest practicable well-being.

3. Incorporation of QIs into the Survey Process

Effective as of July 1999, HCFA has incorporated the use of eleven quality indicator (QI) domains into the long-term care oversight process. These QI domains are comprised of twenty-four indicators falling under the headings of accidents, behavior/emotional patterns,

clinical management, cognitive patterns, elimination/incontinence, infection control, nutrition/eating, physical functioning, psychotropic drug use, quality of life, and skin care, and are currently being used to focus nursing facility surveys. The QIs were developed by the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin under contract with the Health Care Financing Administration (HCFA) and are based on the MDS 2.0.

4. Elimination of SNF/ICF Distinction

OBRA '87 eliminated staffing distinctions that existed between intermediate care facilities (ICFs) and skilled nursing facilities (SNFs). This means that all nursing facilities are now required to have twenty-four hour licensed nursing staff. Facilities are also required to have a registered nurse on duty for at least eight hours a day, seven days a week.

In keeping with the statutory intent to focus on outcomes rather than process, the current Requirements for Participation for Long Term Care Facilities, promulgated as a result of OBRA '87, mandate that facilities have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident..."

When raising the staffing standards for all facilities to meet SNF requirements, one concern of Congress was that the result would be an inadequate supply of nursing personnel. In an effort to avoid imposing an unfair burden on nursing facilities, a provision for a waiver was included in the statute. However, in the interests of resident safety and welfare, certain qualifying criteria were also included. Under current regulations, requirements for licensed nursing may be waived under seven conditions: Among these seven are: (1) "the facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts, to recruit appropriate personnel"; (2) "the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility"; and (3) "the State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility."

While there was some initial concern that numerous requests from nursing facilities for staffing waivers would be forthcoming, this situation has not materialized, and few, if any, waivers have in fact been granted. The future of this status cannot be assured, however, and facilities may find themselves in the position of being forced to make these requests. Today, at least the state of Wisconsin is experiencing an acute shortage of professional nurses. Despite the fact that Good Shepherd's documentation system is completely automated and efficient, in the last six months, several of our nurses have left long term care because of the stress related to excess paperwork and low industry wages.

5. Nurse Aide Training

In developing the nursing home quality of care provisions, Congress also recognized the magnitude of care provided by nurse aides. Nurse aides employed by nursing facilities are required to meet minimum training and competency evaluation requirements that do not apply to other health care settings. Facilities are prohibited from using any individual as a nurse aide for more than four months on a full-time basis, unless that individual has successfully completed at least a 75-hour training and competency evaluation program, or a competency evaluation program, approved by the State. HCFA's final rule on nurse aide training, published

in the Federal Register on September 26, 1991, included a core curriculum with required training in such areas as: infection control; communication and interpersonal skills; safety and emergency procedures; promoting resident independence and respecting resident rights; basic nursing skills; caring for the resident's environment; and personal care skills.

Impact of OBRA '87

Since the implementation of OBRA '87 and the resulting federal regulations, several studies have found significant improvements in quality of care and resident outcomes in nursing facilities, including reductions in the use of psychotropic drugs and physical restraints. A 1995 study funded by the Health Care Financing Administration found significant reductions in decline [and need for assistance] among residents in such areas as activities of daily living, bathing dressing, locomotion, toileting, transferring, and eating. The study also found a 26% decrease in hospitalizations among nursing home residents. This reduction reflects not only increased resident well-being, but also a positive impact on Medicare expenditures, yielding an estimated savings to the Medicare program in hospital costs alone of more than $2 billion per year in 1992 dollars.

AAHSA supported the passage and implementation of OBRA. We were one of the initial members of the Campaign for Quality Care, the coalition of organizations coordinated by the National Citizens' Coalition for Nursing Home Reform, that worked to reach consensus on twelve key areas of nursing home reform. Throughout the phase-in of nursing home reform, AAHSA has continued to serve on various committees and workgroups convened by the Health Care Financing Administration to work toward a reasonable and equitable implementation of the regulations and interpretive guidance resulting from the OBRA requirements. As a national association we have remained an advocate for the presence of these federal standards because we believe that many of the policies and care practices of our members have been enhanced as a result of their existence.

Outcomes vs. Staffing Ratios

Both the provider and consumer communities have long supported the shift from process to outcomes as a means of assessing quality of care. Any attempt to assure the provision of optimal care based on mandated nurse staffing ratios would defeat all of the efforts that have been made within both the legislative and regulatory arenas to achieve this goal. Additionally, any assumptions of quality based on numbers of nursing staff and nursing hours rather than on efficient use of nursing staff and resident outcomes is simplistic and potentially deceptive.

First, while too little staffing is certainly likely to lead to poor outcomes, there has never been any proven correlation between higher staffing levels and the guarantee of positive outcomes. Second, inherent in any mandate for staffing ratios is the danger that the minimum will become the maximum. This scenario is even more likely in the managed care environment and the accompanying climate of cost containment.

Finally, a mandate for nurse staffing ratios discounts the growing role of technology in nursing facilities. One example that can be cited from the past is the mechanical lift. Prior to its implementation, two nurses or nurse aides were required to lift one resident. With the new lifts available today, one nurse or aide can perform the task, cutting the number of required staff by half. This raises the question of whether staffing ratios would have to be recalculated every time a new mode of technology is developed that can substitute for, and possibly perform

better than, human intervention.

OBRA '87 and the Federal regulatory system already assure adequate protection for residents through requirements that facilities "have sufficient nursing staff...." as noted above. Failure to comply with these requirements subjects nursing facilities to State and Federal enforcement actions. Any further specification of staffing numbers or ratios is excessive and undermines the focus on resident outcomes as an effective barometer of care.

The Changing Environment of Nursing Facilities

The OBRA '87 nursing facility reform amendments were primarily designed to ensure the provision of quality care to the chronically ill, elderly "long-stay" resident such as those individuals with Alzheimer's disease and related dementias. While the need to assure optimal care to these residents certainly remains, the years since the passage of OBRA '87 have seen significant change in the residents served in our organizations. Today, nursing home providers also serve a new "constituency". These are individuals who are patients, not residents, who are younger, and who are admitted for short-stay or transitional services such as post-acute or sub-acute care, intensive rehabilitation services, hospice, and respite care. This population shift has dramatically affected the operations of many of our homes. The length of stay for individuals has dramatically declined, but the paperwork and staff time required by the Medicare PPS (prospective payment system) system has multiplied. In the first six months of 1998, prior to implementation of PPS, the staff at Good Shepherd conducted 46 MDS assessments on our Medicare population. During the same time period this year with PPS, our staff completed 124 assessments. The average RAI assessment takes approximately four hours to complete.

The need to effectively respond to the varying intensity of care required by these patients and residents through different levels of staffing has already become evident to nursing facilities. The ongoing ability for facilities to determine staffing ratios based on acuity levels and case mix will become even more pronounced as these changing populations continue to increase. The establishment of minimum staffing levels in the present environment is likely to result in maximums that will be insufficient in years to come. Additionally, since best practices for these different specializations are just emerging, particularly for the care of Alzheimer's residents, the dictating of any type of model staffing level at this point in time would be extremely premature.

Nursing Education

Traditionally, nursing students have received little training geared specifically toward the care of geriatric patients. AAHSA has long supported efforts to increase academic awareness and opportunities for nursing experience in long term care settings. We have emphasized that nursing education and training must be designed to include care of the very frail and elderly as an integral component of the curriculum.

AAHSA has encouraged our nursing home members to open their doors to nursing schools and to offer opportunities for rotation through their facilities. We have also supported the concept of career ladders for nursing assistants to enter the field of professional nursing. Since 1989 the Association has, under a grant from the Patient Care Division of Proctor and Gamble, sponsored an annual scholarship program for nursing assistants to become RNs or LPNs. In addition, we have many nursing facility members who have independently developed scholarship or tuition assistance programs to enable nurse aides under their employ to

become registered (RNs) or licensed practical nurses (LPNs).

AAHSA believes that further demonstrations at the federal level should create opportunities for exposure and entry of nurses into the field of long term care. Such actions could include the initiation of long term care nursing demonstration projects under the auspices of the Public Health Service, Bureau of Health Professions, Nursing Division, to support the development of innovative curriculum for nursing students that would include rotation through facilities. Another recommendation would be that the Federal government earmark loans with forgiveness programs for nurses who enter long term care as a field of practice. Such projects would serve to increase awareness of the long term care nursing experience for both individuals and educational institutions, motivate entry into nursing facility care as a field of practice, and ultimately enhance the quality of care being provided to the residents of these facilities.

Specialized Training

AAHSA has developed a proposal to help alleviate the problem of staff shortages, particularly, at mealtimes [See attached]. We continue to support nurse aide training and competency evaluation programs for nursing assistants. However, in the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents, either by personal choice or as an integral part of their job. Permitting these individuals to perform tasks determined to be non-nursing-related may offer some relief to the nursing assistant shortage.

Three areas of potential non-nursing employee assistance have been identified. Assistance with dining is probably the most frequently cited of these areas. The others are transporting and mobility, and activities. Examples include a dietary aide who might be permitted to help residents cut their food and eat birthday cake at a party, or office personnel and activity assistants who might assist with transferring during a special event or outing. Special outings and social events are the most commonly cited examples of need for use of non-nursing personnel contact with residents. However, if permitted, some employees or senior volunteers may also choose to use their lunch hour to help in the dining room, or housekeeping staff may respond to a resident request to push a wheelchair.

The ability for non-nursing employees to provide assistance would be based on the needs and potential risks to the individual, as identified in the comprehensive assessment and determined by the licensed nurse responsible for the resident. For example, feeding a resident with a swallowing problem would be considered nursing-related, while assisting an alert and competent resident with a paralyzed or immobilized arm would not. Personnel and volunteers performing non-nursing-related tasks would be required to complete relevant in-service training approved by the regulatory authority and demonstrate competence in the duties assigned.

WELLSPRING

Since the passage of OBRA'87, the Federal/State oversight process for nursing facilities has been moving toward greater use of data and internal quality assurance and outcome measures. The quality indicators have been incorporated into the survey process. As a result, "feedback reports" are available that provide facility specific comparative data and the QI status of every resident. The critical question becomes how to use the data. AAHSA believes that one of the most innovative CQI processes have been instituted by an alliance of facilities in Wisconsin.

Today, I would like to speak to you about the process that has been implemented at Good Shepherd through our Wellspring alliance. Wellspring was founded in 1995 and is currently an alliance of 11 independent elder care facilities, located in eastern Wisconsin. The facilities are characterized by an entrepreneurial spirit, zeal for improving the life and care of residents, and a willingness to entirely cooperate and collaborate with each other. These facilities range in size from a 63-bed skilled nursing facility to a 415 bed long-term care home, which is part of a continuing care campus. In addition, Wellspring members offer an array of facilities and services to their respective communities.

Wellspring has integrated the federal quality indicators, best practices and a new management paradigm to dramatically improve resident outcomes and cost efficiency. Fundamental to the Wellspring program is the concept that the definition of quality care is created by top management, but that the best decisions about how the care is delivered to each resident are made by the front-line staff who know the residents best. This empowerment is achieved through extensive line staff education in the form of "care resource teams", shared decision-making and enhancing critical thinking skills of all staff. The program is lead by a geriatric nurse consultant who utilizes other clinical experts for teaching best practices.

Wellspring has integrated quality monitoring pathway tools, which are used to investigate the QI report in order to determine if there is really a problem with resident care. The current QIs are merely markers or flags that may indicate potential problems with care. The true key to providing sustainable quality care is teaching line staff critical thinking techniques which are used to investigate the reports, collect relevant data and finally implement processes that improve quality.

Group process is central to Wellspring. The shift from traditional autocratic management structure to staff empowerment where line staff have equal responsibility for resident outcomes is what has made Wellspring unique. Key components at Good Shepherd have been establishing permanent staff assignments to groups of residents and allowing staff to do their own scheduling.

As a result of this process, Good Shepherd has consistently achieved a 98% resident/family satisfaction. Despite a 2% unemployment rate in Wisconsin, our CNA turnover has been cut from 105% to less than 30% since implementation of Wellspring. Many staff have to drive 20 miles to our rural facility, but several times over the past three years, we have had a waiting list of CNA applicants. Staff retention has remained consistently high over the past four years as well. Good Shepherd completed its fourth consecutive perfect federal/state inspection in 1999.

Payment Systems

Reimbursement rates and policies for nursing facilities must also be considered in addressing the adequacy of nurse staffing and the viability of programs such as Wellspring. A 1988 report by the Commission on Nursing of the Department of Health and Human Services found that on average, registered nurses in nursing facilities earned 35 percent less than their hospital counterparts. Similar salary differentials existed for licensed practical nurses, nurse aides, and other nursing personnel in the same area. Such disparities in salary levels for long term care staff are due, in large part, to inadequate Medicaid reimbursement rates and the Medicare cost limits that establish and restrict the amounts that can be reimbursed for the costs of nursing care.

With the positive national economy, we feel the crunch across our entire organization and not just in the nursing department. In our area, fast food restaurants have higher starting wages than many of our staff. Since as much as 70 percent of the cost of nursing facility care is attributable to staffing, such limits on reimbursable expenses continue to have a chilling effect on salaries. Nursing facilities are unable to offer wages competitive with other health care settings and the general market place.

Federal policy should assume more responsibility for assuring that State Medicaid programs be required to provide adequate payment for all costs of care to Medicaid residents, including nursing care. Consideration should also be given to increasing Medicare cost limits, specifically for nursing.

In addition, the negative public perception that is fostered through the media and sensational reports that focus only on the harmful incidents and occurrences in nursing facilities are demoralizing to front-line workers. We recognize and concur that these incidents are intolerable. However, the kind and compassionate care that is provided on a daily basis, in fact, in greater numbers than the horror stories, go without notice. Portraying the entire nursing home profession in a negative light is unfair to the many dedicated staff who work continuously to assure quality care to the residents they serve. Not only does this do a disservice to these individuals, it further and severely impedes our ability to recruit and retain competent, caring individuals. The long-range impact of "negative only publicity" on our organizations is essentially inestimable.

Conclusion

The measure of a nursing facility's ability to successfully meet its residents needs must be based on actual performance rather than on the potential capacity of the facility to provide appropriate services. AAHSA believes that the impetus provided by OBRA '87 to shift the focus from paper compliance to resident outcomes has gone a long way toward ensuring the provision of optimal quality care to all residents of skilled nursing facilities and nursing facilities.

AAHSA concurs with the efforts of both Congress to promote the attainment of positive outcomes through the study and assurance of the adequacy of nursing personnel in long-term care institutional settings. For nursing facilities, this goal can only be achieved through: (1) continued movement toward quality of care assessment based on resident outcomes rather than process; (2) ongoing efforts to define positive outcomes within the context of these populations; (3) maintenance of facilities' ability to achieve these outcomes by determining staffing needs and targeting resources based on the populations they serve; (4) the development of valid and reliable quality monitoring systems that incorporate not only clinical indicators, but also resident perceptions and satisfaction; (5) the assurance of adequate reimbursement rates by State Medicaid programs and an increase in Medicare cost limits, specifically for staffing; and (6) by increasing academic awareness and opportunities for nursing experience in these long term care settings.

AAHSA urges the Committee to support these recommendations as a means of assuring adequate staffing and the provision of quality care to nursing facility residents. The establishment of mandated nurse staffing ratios can only serve to hinder rather than enhance the achievement of this goal.